

#### Members

Rep. William Crawford, Chairperson  
Rep. Charlie Brown  
Rep. Clyde Kersey  
Rep. David Frizzell  
Rep. Timothy Brown  
Rep. Mary Kay Budak  
Sen. Patricia Miller  
Sen. Robert Meeks  
Sen. Connie Lawson  
Sen. Billie Breaux  
Sen. Rose Ann Antich-Carr  
Sen. Vi Simpson



## SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT

*Legislative Services Agency*  
200 West Washington Street, Suite 301  
Indianapolis, Indiana 46204-2789  
Tel: (317) 233-0696 Fax: (317) 232-2554

#### LSA Staff:

Al Gossard, Fiscal Analyst for the Commission  
Eliza Houston, Attorney for the Commission  
Casey Kline, Attorney for the Commission

Authority: IC 2-5-26

### MEETING MINUTES<sup>1</sup>

Meeting Date: October 18, 2004  
Meeting Time: 9:00 A.M.  
Meeting Place: State House, 200 W. Washington St.,  
Senate Chambers  
Meeting City: Indianapolis, Indiana  
Meeting Number: 3

**Members Present:** Rep. William Crawford, Chairperson; Rep. Charlie Brown; Rep. Clyde Kersey; Rep. David Frizzell; Sen. Patricia Miller; Sen. Connie Lawson; Sen. Billie Breaux.

**Members Absent:** Rep. Timothy Brown; Rep. Mary Kay Budak; Sen. Robert Meeks; Sen. Rose Ann Antich-Carr; Sen. Vi Simpson.

#### Call to Order

Rep. Crawford, Chair, called the third meeting of the Select Joint Commission on Medicaid Oversight to order at 9:15 a.m.

#### Continuous Eligibility

Mr. David Roos, State Program Director, Covering Kids and Families of Indiana, provided the Commission with two handouts: (1) written testimony entitled "12-Month Continuous Eligibility Proposals for Improvement" (See Exhibit 1); and (2) a one-page summary of two specific recommendations for action (See Exhibit 2).

Mr. Roos urged the legislature to reinstate 12-month continuous eligibility as soon as the state

---

<sup>1</sup> Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of \$0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is <http://www.ai.org/legislative/>. No fee is charged for viewing, downloading, or printing minutes from the Internet.

fiscal crisis ends and the budget situation improves. According to Mr. Roos, 12-month continuous eligibility improved retention and continuity of care for Indiana's children when it was first introduced, and it can do it again with the General Assembly's help. He added that there is no reason to believe that all the children who have lost coverage since continuous eligibility was eliminated were truly ineligible. Therefore, it is only fair and just to provide them equal access to the Medicaid and CHIP benefits, which federal and state law authorize.

He also recommended that the Commission reconvene the Renewal Task Force that was originally created by the Children's Health Policy Board in order to develop specific plans to improve the process of renewing coverage in Medicaid, CHIP, and related programs administered by FSSA. The Renewal Task Force should be charged to help:

- (1) Establish baseline case closure and renewal data for all 92 counties prior to January 2005 and agree upon a schedule for reporting comparable trend data back to the Commission.
- (2) Develop a process and supporting technology to allow managed care organizations (MCOs), Prime Step primary medical providers (PMPs), and other providers to help FSSA update their enrollee contact information, thereby increasing the opportunity for effective communication about renewal requirements.
- (3) Develop a process and supporting technology to allow FSSA to share renewal dates and renewal notices with MCOs, Prime Step PMPs, and other providers, thereby increasing the opportunity that recipients will fulfill appropriate renewal requirements.
- (4) Review, revise, and reissue existing policies which allow local Division of Family and Children (DFC) offices to work with community-based enrollment centers to assist with the Medicaid and CHIP renewal process, and offer training and support to local DFC offices necessary to successfully implement these policies.
- (5) Develop a process and supporting technology to allow FSSA to better utilize shared information from other state information systems to help retain Hoosier Healthwise enrollment rather than merely trigger a "flash bulletin" that may in fact increase disenrollment due to procedural and compliance reasons.
- (6) Develop an educational and marketing campaign to increase enrollee understanding and compliance with appropriate Hoosier Healthwise renewal and information update requirements.

Ms. Melanie Bella, Assistant Secretary of FSSA for the Office of Medicaid Policy and Planning (OMPP), indicated that OMPP would gladly continue working at sharing enrollment information. She added that some data items would not be available by January, however, enrollment data can be shared. She also indicated that it would be useful to minimize the number of task forces and committees that the administration has to be involved with so that resources can be used for providing services.

Both of the recommendations were endorsed unanimously by the Commission and incorporated into the Commission's final report.

### **Consideration of Legislative Proposals**

#### ***PD 3547 - Medicaid Services for Foster Care Individuals***

PD 3547 requires OMPP to apply for an amendment to the state Medicaid plan and, if necessary, apply for a Medicaid waiver to provide services to individuals who are at least 18 years of age but less than 22 years of age and are receiving or have received foster care (See Exhibit 3).

Rep. Crawford indicated that this proposal was a product of the Commission on Abused and Neglected Children. He added that the fiscal impact estimated by the Commission was \$600,000 (state and federal) in year one, \$1.2 M in year two, and would level out at \$1.7 M in year three and future years.

Ms. Bella indicated the administration's position at this time is that anything with a fiscal impact is problematic.

After being properly moved and seconded, the motion to recommend PD 3547 was passed unanimously, 7 to 0.

#### ***PD 3307 - Medicaid Health Facility Quality Assessment***

PD 3307 provides that if a health facility fails to pay the quality assessment to the Department of State Revenue or a nursing facility fails to pay the quality assessment to the Office of Medicaid Policy and Planning, the State Department of Health must notify the facility and revoke the facility's license (See Exhibit 4).

Ms. Bella explained the proposal and updated the Commission on the status of the quality assessment approval process with the Centers for Medicare and Medicaid Services (CMS). She added that OMPP was close to getting approval, and CMS has suggested some changes to OMPP's submission. Mr. Steve Albrecht, Indiana Health Care Association, provided clarification on the nature of the CMS suggestions. Members of the Commission requested to be kept informed of the impact of the quality assessment fee on individual nursing facilities as a result of any plan modifications.

After being properly moved and seconded, the motion to recommend PD 3307 was passed unanimously, 7 to 0.

#### ***Lead Poisoning and Children***

The next proposal was based on PD 3555 which requires OMPP to establish: (1) measures to evaluate Medicaid managed care organizations in screening children for lead poisoning; (2) a system to maintain the results of the evaluation; and (3) a performance incentive program. The bill also requires the State Department of Health to adopt rules for case management of children with lead poisoning (See Exhibit 5).

A second draft was provided to the Commission (See Exhibit 6) which was identical to PD 3555 with the exception of the age of the children for whom the bill applies. The draft under consideration applies to children under the age of seven, while PD 3555 applied to children under the age of 19. Mr. Tom Neltner, President of Improving Kid's Environment, explained the draft and provided a document describing the State Department of Health and OMPP partnership activities to prevent lead poisoning in Indiana (See Exhibit 7). Ms. Bella indicated that the administration supports the proposal.

After being properly moved and seconded, the motion to recommend the draft was passed unanimously, 7 to 0.

### **Consideration of the Final Report**

The draft final report was approved assuming the incorporation of testimony and written materials provided to the Commission since the second meeting, and the inclusion of the continuous eligibility recommendations approved earlier in this meeting. After being properly moved and seconded, the motion to approve the final report with the noted changes was passed unanimously, 7 to 0.

The Commission also approved by unanimous voice vote a recommendation to the Legislative Council that the Select Joint Commission on Medicaid Oversight be exempt from the three-meeting restriction imposed on study committees (Legislative Council Resolution 04-02, SECTION 7(f)).

### **"Suspend, Not Terminate" Issue**

Ms. Annette Biesecker, Legislative Director for FSSA, briefed the Commission on the May 25, 2004, letter from Glenn Stanton, Acting Director, Disabled and Elderly Health Programs Group, CMS (See Exhibit 8). Ms. Biesecker explained that current policy in Indiana is to terminate an individual's Medicaid eligibility 60 days after incarceration in a correctional facility. The CMS letter indicates that states are encouraged to only suspend eligibility, rather than terminate (based solely on their status as inmates or residents), for individuals who are inmates of public institutions or residents of institutions for mental disease.

Ms. Biesecker stated that suspending, instead of terminating, eligibility adds little benefit, while adding significant administrative burden onto the state. She added that the Department of Correction and FSSA intend to share in the cost of case managers for inmates scheduled for release and coordinate medical records. FSSA is currently doing this in the state hospital setting.

### **Recreational Therapists**

Ms. Vicki Scott (Program Manager for Hook Rehab Center in Indianapolis), Ms. Heather Sedletzke (a certified recreational therapist and provider of services in the Developmental Disability and Autism Waiver programs), and Dr. Bryan McCormick (PhD and President of the American Therapeutic Recreation Association) made the following recommendations to the Commission: (1) modify the Indiana Administrative Code for the Medicaid Program so that the wording does not exclude the provision of services by recreational therapists and (2) amend the Traumatic Brain Injury (TBI) Waiver and the Aged and Disabled (A&D) Waiver to add recreational therapy as a covered service (See Exhibit 9 for written testimony and Exhibit 10 for chronology of the issue). They added that adding recreational therapy as a covered service would represent no fiscal impact to the state because the service is added to a list of services that must be provided within a fixed budget. They also indicated that New Mexico is the only state which reimburses recreational therapy services in the waiver program, while several states include recreational therapy as a regular Medicaid service.

Ms. Annette Biesecker, FSSA, stated that these services are already available under the other Medicaid waivers. However, recipients under the TBI and A&D waivers do not have the same active therapy requirements. She added that adult day services are already provided under the TBI and A&D waivers, and these services are more cost-effective and appropriate than recreational therapy for these populations. Ms. Biesecker added that there is no way currently for FSSA to enforce a budget and that the budget largely depends upon the case manager,

although the budget must be approved by FSSA.

### **Health Disparities/Medical Interpreters**

Ms. Nancy Jewell, President and CEO of the Indiana Minority Health Coalition, provided a slide presentation (See Exhibit 11) on health disparities faced by minorities and on the issue of medical interpreters. Ms. Jewell discussed the three primary groups that are most disproportionately affected by health disparities: rural and urban minorities, and Caucasian populations in rural areas. The health conditions that have greater rates in minority populations include infant mortality, HIV/AIDS, hepatitis, syphilis, tuberculosis, obesity, and end stage renal disease. Rural populations are subject to higher rates of unintentional injuries, cerebrovascular disease (strokes), and suicide. Ms. Jewell discussed barriers to healthcare access and several recommendations for action.

Ms. Jewell also provided members with several maps showing the (1) most populated minority counties by minority health coalition site, (2) Indiana health professionals shortage areas (HPSA) for dental care, (3) HPSAs for mental health, (4) HPSAs for primary care, (5) Indiana medically underserved areas and populations, and (6) HPSAs and medically underserved populations, combined. (See Exhibit 12.)

Rep. Crawford stated that Indiana has been lauded for using its Tobacco Settlement money for health purposes, but there will be a lot of pressure to shift this money out of the health area because of the state's fiscal situation.

### **Audits of Waiver Providers**

Ms. Melanie Bella, OMPP, briefed the Commission on the administration's policy and procedures for the conduct of audits of providers of services under the Medicaid home and community-based services waiver program. Ms. Bella provided a handout (See Exhibit 13) with details regarding OMPP policy on this matter, procedures, reasons for recoupment of provider payments, number of providers anticipated to be audited each year, and the appeal process.

Ms. Jean MacDonald, Director of Public Policy for the Indiana Association for Home and Hospice Care, presented a document to members (See Exhibit 14) describing the various audits that her members are subject to, specific complaints about the waiver audit process, and two letters from Mr. Todd Stallings, Executive Director of the Indiana Association for Home and Hospice Care, to OMPP regarding the audit process.

Ms. Bella also provided members with a letter from OMPP to Mr. Todd Stallings (See Exhibit 15). The letter provides an OMPP response to several questions raised by the Association and additional details about the audit process.

Ms. Claudia Chavis, owner of Caregivers Home Services, told members about the audit of her agency. She also related that two other provider agencies were in attendance, but due to the length of the meeting would not testify.

Rep. Crawford requested that OMPP provide an update to the Commission in three months about this issue and whether the state has lost any providers because of it.

### **Chronic Disease Presentation**

Dr. Greg Wilson, M.D. and Commissioner of the State Department of Health, and Ms. Melanie Bella, OMPP, provided a slide presentation on Indiana's Chronic Disease Management Program (See Exhibit 16). The presentation included background on the status of Indiana citizens relative to the nation on various health statistics and indicators, including heart disease, cancer, smoking, prenatal care, stroke, diabetes, and obesity. Information was also provided on the specific program principles and operation of the chronic disease program, accomplishments to date, and directions of the program, and challenges faced by the program.

Members complimented Dr. Wilson and Ms. Bella for their efforts in developing the program and the successes already realized by the program.

Mr. Jim Bozora, Director of State and Federal Government Programs for the AIDS Healthcare Foundation, and Ms. Donna Stidham, Chief of Managed Care for the foundation, distributed a packet to Commission members (See Exhibit 17) and spoke on disease management as it specifically relates HIV/AIDS. They discussed the Positive Healthcare Disease Management Program, an affiliate of the AIDS Healthcare Foundation, and specific disease management programs in Florida and California. They also provided recommendations to the state on what the state should seek in a successful HIV disease management program.

### **Maine and Hawaii Rx**

Ms. June Lyle, AARP of Indiana, introduced Mr. John Luehrs and Ms. Cathy McDougall, both of AARP, to provide a slide presentation on Rx+, a program to help individuals without prescription drug insurance coverage to obtain prescription drugs at a reduced cost (See Exhibit 18). The Rx+ program entails using the purchasing power of the state to negotiate prices, discounts, and rebates from drug companies. They further explained that Maine was the first state to enact such a program, and Hawaii, the District of Columbia, and Rhode Island have since enacted Rx+. Idaho, New York, Tennessee, and Washington are considering introduction in 2005. The program would use the Medicaid preferred drug list to negotiate for better state rebates and would pass the savings and discounts on to eligible residents. Sen. Lawson expressed concern as to whether the ability to negotiate lower prices for drugs for the uninsured would drive up costs in other parts of the health care system, such as pharmacy expenditures paid by health insurance.

### **Update on Fraud and Audit Activities**

Ms. Bella, OMPP, and Allen Pope, Director of the Medicaid Fraud Control Unit in the Office of the Attorney General, briefed the Commission on the fraud detection and audit activities of the Office of Medicaid Policy and Planning and the Attorney General's office (See Exhibit 19). Ms. Bella stated that OMPP has daily operational oversight of the program and described the various contractors involved in the program integrity function: Myers and Stauffer (claims data analysis), Prudent Rx (specialized pharmacy audits), Health Care Excel (Surveillance Utilization Review), and EDS (front-end denial of claims and audit of waiver providers). In addition, the Medicaid Fraud Control Unit in the Attorney General's office investigates potential fraudulent activity and returns nonfraud cases to OMPP. Ms. Bella added that the various contractors provide feedback to OMPP potentially resulting in system changes on the front end of the process to better detect errors and fraudulent activity. Exhibit 19 provides additional description of the audit process.

Mr. Pope stated that over a four-year period, there have been 28 convictions for provider fraud.

Members of the Commission requested additional information on the 28 convictions and also requested additional information on the reports submitted to federal authorities.

### **Hemophilia**

Ms. Michelle Rice, Hemophilia of Indiana, spoke on the problems faced by hemophiliacs in paying for their blood factor replacement therapy. A position statement was previously distributed to members (See Exhibit 20). She indicated that insurance policies often don't reimburse for blood factor. She added anecdotally that factor replacement for an individual undergoing knee surgery costs from \$600,000 to \$800,000. She also indicated that OMPP was trying to establish reimbursement rates, but people suffering from hemophilia were in need of a solution.

Ms. Rice indicated that hospitals have a very difficult time stocking blood factor products because of the expense, different types of factor required for different individuals, and that some factor would be stocked and not used before it went out of date. She suggested a short-term solution for patients to bring their own factor replacement with them to the hospital. However, they were encountering problems with this solution, especially in terms of liability issues of a patient bringing their own drugs to the hospital.

Mr. Tim Kennedy, Indiana Hospital and Health Association, agreed with Ms. Rice that a problem exists. He indicated that they were working on the issues, but he suggested that there was, indeed, a liability issue associated with allowing people to bring their own factor to the hospital and that there is an expense and risk that is uniquely associated with hemophilia.

### **Other Business**

#### *Chicago Children's Hospital Issue*

Ms. Bella, OMPP, was asked for an update of the Chicago Children's Hospital issue where the hospital was no longer accepting Medicaid patients. Ms. Bella stated that the state has still been unable to resolve the issue and that there was still disagreement over the data. She indicated that she has heard of four cases of children who needed care, but that a hospital provider had been found for these children. She added that OMPP was looking for alternative providers and that the University of Chicago hospital was taking some of the children.

#### *Inpatient Psychiatric Care Reimbursement Rates*

Mr. Jim Jones, Indiana Council of Community Mental Health Centers (CMHCs), briefed the Commission on the problem of Medicaid reimbursement for inpatient psychiatric services. He indicated that every two years, Medicaid rates for hospital services are rebased. In the latest rebasing that will be effective November 1, rates for inpatient psychiatric services were drastically reduced (from \$408.50 per day to \$309.35 per day). Mr. Jones stated that it was his understanding that funds were being intentionally shifted from inpatient psychiatric services to OBGYN services in the rebasing. He added that typically, one-third of revenue for CMHCs comes from Medicaid, so the rebasing will have a tremendous impact on CMHCs, possibly resulting in the reduction of bed capacity and additional access problems. He also stated that he and OMPP had a meeting scheduled for later in the day, and the issue might be resolved at that time.

Mr. Tim Kennedy, Indiana Health and Hospital Association (IHHA), affirmed that in the course of rebasing, reimbursement has been shifted from inpatient psychiatric services to OBGYN

services, and it was the position of his association that the funding should be shifted back to inpatient psychiatric services.

Mr. John McCrory, a member of the National Alliance for the Mentally Ill, stated that this problem is far-reaching and affects the entire health care system in Indiana, not only hospitals. This includes emergency rooms and the criminal justice systems.

Rep. Crawford stated that the General Assembly has not forsaken mental health issues. Several provisions have been implemented recently, including a forensic diversion program and mandatory training of law enforcement officers on mental health issues. He added that there is also a Commission on Mental Health, which is an additional forum for these issues.

Ms. Bella stated that OMPP had discussions with the IHHA, but had neglected to talk with the Association for CMHCs. Mr. Jones had provided OMPP with additional information, and she has been working with Mr. Jones to identify \$17 M in additional Disproportional Share Hospital program payments while these issues are being worked out.

### **Adjournment**

There being no further business to conduct, Rep. Crawford adjourned the meeting at about 1:25 p.m.

### **Additional Materials Distributed to Commission Members**

Additional materials distributed to Commission members prior to the third meeting included the following:

- (1) A memo from Mr. Mike Fowler, Director of Data Management and Analysis, OMPP, involving information requested on Hoosier Healthwise and the repeal of continuous eligibility (See Exhibit 21).
- (2) A report from EDS, "Indiana Medicaid Program Update," showing Medicaid Program statistics, Medicaid spending for various services, operational statistics, and certain Medicaid Program highlights. (See Exhibit 22.)
- (3) A report from the State Department of Health submitted to the Commission in compliance with the provisions of SEA 225 (2001). (See Exhibit 23.)
- (4) A report from the State Department of Health submitted to the Commission in compliance with the provisions of SEA 396 (2003). (See Exhibit 24.)
- (5) A report from OMPP entitled "Providers with Claims Activity by County for Key Specialties." (See Exhibit 25.)